

Division of Health Care Facilities

PRINTED: 05/24/2012
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/24/2012
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY HEALTH AND REHAB CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During complaint investigation number 28399 and 29302, conducted on May 23, 2012, at Jefferson City Health and Rehab Center, no deficiencies were cited in relation to the complaints under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

vision of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE FORM

6899

I1T311

If continuation sheet 1 of 1